STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	291500	A. BUILDING _____ B. WING _____	C 03/31/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATHAN ADELSON HOSPICE	4141 S SWENSON LAS VEGAS, NV 89119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your hospice on 3/6/09 and concluded on 3/31/09. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions, or other claims for relief that may be available to any party under applicable federal, state or local laws. Two (2) complaints were investigated: Cpt #NV00020555-Unsubstantiated Cpt #NV00021190-Substantiated with deficiencies (TAG L 510) The following deficiencies were identified.	L 000		
L 510	418.52(b)(4)(iii) EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON [The hospice must:] (iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure corrective action was taken by notifying local law enforcement after an alleged violation was verified by the hospice administration for one patient (#1). Findings include: The patient was an 82 year old female admitted	L 510		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 510	Continued From page 1	L 510		

on 2/5/09, with a diagnosis of debility. She was alert and oriented times three.

On 3/6/09 at 4:00 PM, Employee #1 indicated Patient #1 revealed on 2/28/09, Employee #2 treated her roughly during morning care. The patient indicated she did not want Employee #2 to take care of her. Employee #1 indicated the patient told Employee #2 to "stop" and he did not while he was giving her peri (perineal) care. Employee #1 indicated Employee #2 was suspended on 2/28/09 and an investigation was conducted. Employee #2 was terminated on 3/2/09 and reported to the Nevada State Board of Nursing. Employee #1 indicated Patient #1's family was notified concerning the incident and they were comfortable with the resulting investigation. Employee #1 indicated Patient #1 did not wish to discuss the incident again.

The Personal Record of Employee #2 revealed no previous incidents of misconduct. The Employee worked at the facility since 9/05.

The investigatory notes on 2/28/09 at 6:50 AM written by the medication nurse indicated, initially Patient #1 indicated the male (Employee #2) Certified Nurse's Assistant (CNA) molested her. She indicated on 2/28/09 at 7:50 AM, to the charge nurse that the CNA, "...rubbed her hard.. and that he seemed like a nice young man, however she preferred a lady to clean me for the remainder of my stay..."

The investigative notes indicated statements were obtained from the patient, the medication nurse, the charge nurse and the CNA who allegedly perpetrated the incident.

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L 510	Continued From page 2	L 510		

The investigatory notes documented by Employee #1 revealed, "On 2/28/09 at 6:30 AM, (nurse's name) RN was passing medications." The nurse stated, "I went into the patient's (Pt.) room to give her medications. Pt. sat up with a sad look on her face. 'That man (Employee #2) molested me... I told him to stop and he didn't...He rubbed me hard...I am not dirty'."

On 2/28/09, Charge Nurse documented (investigatory report), "The patient stated, (Employee #2) Certified Nurse's Assistant was 'Kinda rough when he was cleaning me up'. She further stated, He was very explicit and hard, very emphatic in cleaning her peri (perineal) area. The patient stated, He seems like a nice young man but would rather have a lady clean me up for the remainder of my stay at (name of facility)."

Patient #1 was interviewed by Employee #3 on Friday 2/28/09. The patient indicated, Employee #2 came into her room and told her he was going to check her to see if she was soiled. Patient #1 indicated Employee #2 told her she had some bowel movement and would have to clean her down there (indicated her perineal area). The patient indicated Employee #2 was very rough and was cleaning her in a way in which she felt uncomfortable. The patient told him to stop. The patient stated Employee #2 said, "I'll stop when I am done." Employee #3 asked the patient what she meant by, "down there." The patient responded appropriately. The patient indicated she did not want to get him in trouble but she told him to stop and he did not. The patient stated, "Everyone else is just fine in here." The patient indicated she just wanted to forget the incident.

Employee #3 documented (investigatory report)

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L 510	Continued From page 3 on 3/2/09, she had a conversation by telephone with Employee #2. She asked Employee #2 to describe what transpired with Patient #1 on 2/28/09. Employee #1 described the incident and added that he should have stopped when Patient #1 told him to stop. Review of the facility policy on Abuse and Neglect on 3/31/09, documented all alleged incidents of abuse will be handled immediately after it is reported. The individual or individuals are immediately suspended until a determination is made as to whether or not the allegation is substantiated or unsubstantiated. A report is made to the Division of Aging, the Bureau of Healthcare Quality and Compliance and if applicable the Licensing Boards. Law enforcement is called if the patient feels they are in danger or if they wish to file criminal charges.	L 510		